	FOR OHF USE				

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE

OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I.	IDPH Facility ID Number: 00  Facility Name: Briarbrook Place	038232		II. CERTI	FICATION BY	AUTHORIZED FACILITY	OFFICER
	Address: 228 Briarbrook Dr. Number  County: Tazewell  Telephone Number: (309) 698-9200	East Peoria City  Fax # ( 309 ) 698-9213	61611 Zip Code	State of and cer are true applical is base	Illinois, for the patify to the best of accurate and courate and courate instructions. It on all informations.	f my knowledge and belief ti omplete statements in acco Declaration of preparer (otl ion of which preparer has ar	/00 to 06/30/01 hat the said contents rdance with her than provider) ny knowledge.
	IDPA ID Number: 371238076005  Date of Initial License for Current Owners:	08/01/92		in this o	ost report may b	sentation or falsification of a pe punishable by fine and/or	imprisonment.
	Type of Ownership:			Officer or Administrator of Provider	(Type or Print !	Name)	(Date)
	x VOLUNTARY, NON-PROFIT x Charitable Corp.	Individual	GOVERNMENTAL State		(Title)		
	Trust IRS Exemption Code 501(c)(3)	Partnership Corporation "Sub-S" Corp.	County Other	Paid	(Signed) (Print Name	SEE ACCOUNTANTS' CO	OMPILATION REPORT (Date)
		Limited Liability Co. Trust Other		Preparer	and Title) (Firm Name	Altschuler, Melvoin and Gl	lasser LLP
		outil		& Address) (Telephone)	One South Wacker Drive, 5 (312) 634-3400	Suite 800, Chicago, IL 60606 Fax ‡ (312) 634-5518	
	In the event there are further questions abou Name: Michael G. Kaplan Please send copies of desk review and	t this report, please contact: Telephone Number: (312) 634-34 audit adjustments to address on this page		ILLIN 201 S.	TO: OFFICE OF HEALTI OIS DEPARTMENT OF P Grand Avenue East gfield, IL 62763-0001		

STATE OF ILLINOIS Page 2

Facil	ity Name & ID Numbe	er Briarbrook P	lace		# 0038232 Report Period Beginning: 07/01/00 Ending: 06/30/01		
	III. STATISTICAI	L DATA					D. How many bed-hold days during this year were paid by Public Aid?
	A. Licensure/co	ertification level(s) of	f care; enter numbe	r of beds/bed days,			(Do not include bed-hold days in Section B.)
	(must agree v	vith license). Date of	change in licensed l	beds	N/A		
		,	o .	_		_	E. List all services provided by your facility for non-patients.
	1 2 3		3	4		(E.g., day care, "meals on wheels", outpatient therapy)	
							None
	Beds at				Licensed		1010
	Beginning of	Licensu	re	Beds at End of	Bed Days During		F. Does the facility maintain a daily midnight census?
	Report Period	Level of C		Report Period	Report Period		1. Does the facility maintain a daily infulight census.
	Report I eriou	Level of	care	Keport i eriou	Report 1 eriou		G. Do pages 3 & 4 include expenses for services or
_		CL TL A CONT	7)			1	
2		Skilled (SNF	atric (SNF/PED)			2	investments not directly related to patient care?  YES X NO Non-allowable costs have been
3		Intermediate	`			3	eliminated in Schedule V, Column 7
4		Intermediate	,			4	•
5		Sheltered Ca				5	H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  YES  NO  X
6	16	ICF/DD 16 o	` /	16	5,840	6	1ES NO A
-0	10	ICF/DD 10 (	or Less	10	5,640	0	I. On what date did you start providing long term care at this location?
7	16	TOTALS		16	5,840	7	Date started 08/01/92
					1 2,010		
							J. Was the facility purchased or leased after January 1, 1978?
	B. Census-For the entire report period.						YES X Date 03/08/99 NO
	1	2	3	4	5		
	Level of Care	Patient Days	by Level of Care an	d Primary Source of	Payment		K. Was the facility certified for Medicare during the reporting year?
	Ecver of care	Public Aid	by Ecret of Care an	Source of	T dyment		YES NO X If YES, enter number
		Recipient	Private Pay	Other	Total		of beds certified 0 and days of care provided N/A
8	SNF	пестрине	111/1100 1 11/	o tine.	1000	8	and any of this provided
9	SNF/PED					9	Medicare Intermediary N/A
10	ICF					10	intermediaty 1//12
11	ICF/DD					11	IV. ACCOUNTING BASIS
12	SC					12	MODIFIED
_	DD 16 OR LESS	5,577			5,577	13	ACCRUAL X CASH* CASH*
10	DD 10 OR EESS	3,377			3,011	10	ACCRETAL A CROSS
14	TOTALS	5,577			5,577	14	Is your fiscal year identical to your tax year?  YES X NO
		supancy. (Column 5, l line 7, column 4.)	line 14 divided by to 95.50%	otal licensed			Tax Year: 06/30/01 Fiscal Year: 06/30/01  * All facilities other than governmental must report on the accrual basis.
	bed days on	mie /, column 4.)	93.30%	_	SEE ACCOUNTAN	NTS' C	All facilities other than governmental must report on the accrual dasis.  OMPILATION REPORT
							w-:

STATE OF ILI	LINOIS				Page 3
#	0038232	Report Period Reginning	07/01/00	Ending	06/30/01

2 Food Purchase	Facility Name & ID Number	Briarbrook Pla			#	0038232	Report Period	Beginning:	07/01/00	Ending:	06/30/01	_
A. General Services	V. COST CENTER EXPENSES (thro	ughout the report	, please round	to the nearest d	ollar)							
A. General Services								•		FOR OHF	USE ONLY	
Dietary		Salary/Wage	Supplies							_		
2 Food Purchase		1	2	-	-	5		7**		9	10	
2,887   2,88	,	18,346		1,731								1
4   Laundry   963   96								(3,060)				2
Section   Sect			,		,		,		,			3
Maintenance			963						, ,,			4
7 Other (specify):* 8 TOTAL General Services 28,349 33,155 24,278 85,782 85,782 (1,977) 83,805 3 8 Health Care and Programs 9 Medical Director 10 Nursing and Medical Records 120,765 4,500 2,569 127,834 127,834 127,834 127,834 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				- /								5
State   TOTAL General Services   28,349   33,155   24,278   85,782   85,782   (1,977)   83,805   3	6 Maintenance	10,003		12,468	22,471		22,471	1,019	23,490			6
B. Health Care and Programs	7 Other (specify):*											7
Medical Director		28,349	33,155	24,278	85,782		85,782	(1,977)	83,805			8
10												
10a   Therapy												9
11   Activities	10 Nursing and Medical Records	120,765	4,500		,		,		,			10
12   Social Services   365	10a Therapy				310		310					10:
13   Nurse Aide Training	11 Activities		5,618		.,			1,702				11
14   Program Transportation   2,907   2,907   2,907   2,907   2,907   1   1   1   1   1   1   1   1   1	12 Social Services			365	365		365		365			12
15   Other (specify):* Routine Dental												13
TOTAL Health Care and Programs   120,765   10,118   7,939   138,822   138,822   1,702   140,524   1	14 Program Transportation			2,907	2,907		2,907		2,907			14
C. General Administration   C. General Administrative	15 Other (specify):* Routine Dental			550	550		550		550			15
17   Administrative   38,903   2,060   40,963   40,963   (2,060)   38,903   1   1   18   Directors Fees   4,706   4,706   4,706   1   1   19   Professional Services   6,232   6,232   6,232   6,803   13,035   1   1   1,262   3,663   2   1   1,262   3,663   3   1   1,262   3,663   3   1   1,262   3,663   3   1   1,262   3,663   3   1   1,262   3,663   3   1   1,262   3,663   3   1   1,262   3,663   3   1   1,262   3,663   3   1   1,262   3,663   3   1   1,262   3,663   3   1,262   3,663   3   1,262   3,663   3   1,262   3,663   3   1,262   3,663   3   1,262   3,663   3,663   3,663   3,663   3,663   3,663   3,663   3,663   3,666   3,663   3,666   3,664   3,664   3,664	16 TOTAL Health Care and Programs	120,765	10,118	7,939	138,822		138,822	1,702	140,524			16
18   Directors Fees	C. General Administration											
19   Professional Services   6,232   6,232   6,232   6,232   6,232   3,663   13,035   1	17 Administrative	38,903		2,060	40,963		40,963	(2,060)	38,903			17
20       Dues, Fees, Subscriptions & Promotions       2,401       2,401       2,401       1,262       3,663       2         21       Clerical & General Office Expenses       14,138       3,833       6,663       24,634       24,634       12,788       37,422       2         22       Employee Benefits & Payroll Taxes:       12,385       12,385       12,385       21,913       34,298       2         23       Inservice Training & Education       10       10       10       299       309       2         24       Travel and Seminar       2,974       2,974       2,974       1,938       4,912       2         25       Other Admin. Staff Transportation       1,941       1,941       1,941       1,941       1,941       178       2,119       2         26       Insurance-Prop.Liab.Malpractice       4,512       4,512       2         27       Other (specify):*       2       2         28       TOTAL General Administration       53,041       3,833       34,666       91,540       91,540       52,339       143,879       2         29       (sum of lines 8, 16 & 28)       202,155       47,106       66,883       316,144       316,144       52,064       368,20	18 Directors Fees							4,706	4,706			18
21       Clerical & General Office Expenses       14,138       3,833       6,663       24,634       24,634       12,788       37,422       2         22       Employee Benefits & Payroll Taxes       12,385       12,385       12,385       21,913       34,298       2         23       Inservice Training & Education       10       10       10       299       309       2         24       Travel and Seminar       2,974       2,974       2,974       1,938       4,912       2         25       Other Admin. Staff Transportation       1,941       1,941       1,941       178       2,119       2         26       Insurance-Prop.Liab.Malpractice       4,512       4,512       2         27       Other (specify):*       2       2         28       TOTAL General Administration       53,041       3,833       34,666       91,540       91,540       52,339       143,879       2         29       (sum of lines 8, 16 & 28)       202,155       47,106       66,883       316,144       316,144       52,064       368,208       2	19 Professional Services			6,232	6,232		6,232	6,803	13,035			19
22       Employee Benefits & Payroll Taxes       12,385       12,385       21,913       34,298       2         23       Inservice Training & Education       10       10       10       299       309       2         24       Travel and Seminar       2,974       2,974       2,974       1,938       4,912       2         25       Other Admin. Staff Transportation       1,941       1,941       1,941       178       2,119       2         26       Insurance-Prop.Liab.Malpractice       4,512       4,512       2         27       Other (specify):*       2         28       TOTAL General Administration       53,041       3,833       34,666       91,540       91,540       52,339       143,879       2         29       (sum of lines 8, 16 & 28)       202,155       47,106       66,883       316,144       316,144       52,064       368,208       2	20 Dues, Fees, Subscriptions & Promotions			2,401	2,401		2,401	1,262	3,663			20
23     Inservice Training & Education     10     10     299     309     2       24     Travel and Seminar     2,974     2,974     2,974     1,938     4,912     2       25     Other Admin. Staff Transportation     1,941     1,941     1,941     178     2,119     2       26     Insurance-Prop.Liab.Malpractice     4,512     4,512     2       27     Other (specify):*     2       28     TOTAL General Administration     53,041     3,833     34,666     91,540     91,540     52,339     143,879     2       TOTAL Operating Expense (sum of lines 8, 16 & 28)     202,155     47,106     66,883     316,144     316,144     52,064     368,208     2	21 Clerical & General Office Expenses	14,138	3,833	6,663	24,634		24,634	12,788	37,422			21
24       Travel and Seminar       2,974       2,974       2,974       1,938       4,912       2         25       Other Admin. Staff Transportation       1,941       1,941       1,941       178       2,119       2         26       Insurance-Prop.Liab.Malpractice       4,512       4,512       2         27       Other (specify):*       2         28       TOTAL General Administration       53,041       3,833       34,666       91,540       91,540       52,339       143,879       2         29       (sum of lines 8, 16 & 28)       202,155       47,106       66,883       316,144       316,144       52,064       368,208       2	22 Employee Benefits & Payroll Taxes			12,385	12,385		12,385	21,913	34,298			22
25         Other Admin. Staff Transportation         1,941         1,941         1,941         178         2,119         2           26         Insurance-Prop.Liab.Malpractice         4,512         4,512         2           27         Other (specify):*         2           28         TOTAL General Administration         53,041         3,833         34,666         91,540         91,540         52,339         143,879         2           TOTAL Operating Expense (sum of lines 8, 16 & 28)         202,155         47,106         66,883         316,144         316,144         52,064         368,208         2	23 Inservice Training & Education			10	10		10	299	309			23
26       Insurance-Prop.Liab.Malpractice       4,512       4,512       2         27       Other (specify):*       2         28       TOTAL General Administration       53,041       3,833       34,666       91,540       91,540       52,339       143,879       2         TOTAL Operating Expense (sum of lines 8, 16 & 28)       202,155       47,106       66,883       316,144       316,144       52,064       368,208       2	24 Travel and Seminar			2,974	2,974		2,974	1,938	4,912			24
26       Insurance-Prop.Liab.Malpractice       4,512       4,512       2         27       Other (specify):*       2         28       TOTAL General Administration       53,041       3,833       34,666       91,540       91,540       52,339       143,879       2         TOTAL Operating Expense (sum of lines 8, 16 & 28)       202,155       47,106       66,883       316,144       316,144       52,064       368,208       2	25 Other Admin. Staff Transportation			1,941	1,941		1,941	178	2,119			25
27 Other (specify):*     2       28 TOTAL General Administration     53,041       3,833     34,666       91,540     91,540       52,339     143,879       29 (sum of lines 8, 16 & 28)     202,155       47,106     66,883       316,144     52,064       368,208     2				· ·	ŕ			4,512	4,512			26
TOTAL Operating Expense 29 (sum of lines 8, 16 & 28) 202,155 47,106 66,883 316,144 316,144 52,064 368,208 2								,	,			27
29 (sum of lines 8, 16 & 28) 202,155 47,106 66,883 316,144 316,144 52,064 368,208 2	28 TOTAL General Administration	53,041	3,833	34,666	91,540		91,540	52,339	143,879			28
		202.1	45.105	66,002	216111		2161::	<b>50</b> 0 5 1	269.200			T
				/	,					)T		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000. SEE ACCOUNTANTS' COMPILATI NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

#### V. COST CENTER EXPENSES (continued)

			Cost Per Gener	al Ledger		Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			2,826	2,826		2,826	18,819	21,645			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,942	2,942		2,942	57,285	60,227			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			66,872	66,872		66,872	(65,102)	1,770			34
35	Rent-Equipment & Vehicles			9,854	9,854		9,854	807	10,661			35
36	Other (specify):*											36
37	TOTAL Ownership			82,494	82,494		82,494	11,809	94,303			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			495	495		495	381	876			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			36,096	36,096		36,096		36,096			42
43	Other (specify):* Nonallowable costs			130,879	130,879		130,879	(130,879)				43
44	TOTAL Special Cost Centers			167,470	167,470		167,470	(130,498)	36,972			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	202,155	47,106	316,847	566,108		566,108	(66,625)	499,483			45

<sup>\*</sup>Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

<sup>\*\*</sup>See schedule of adjustments attached at end of cost report

Page 5

**Ending:** 

# 0038232 Report Period Beginning:

07/01/00

06/30/01

4

VI. ADJUSTMENT DETAIL A. 7

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	1
		-	Refer-	OHF USE	
	NON-ALLOWABLE EXPENSES	Amount	ence	ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(133,451)	43		3
4	Non-Patient Meals				4
	Telephone, TV & Radio in Resident Rooms	(522)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(2,804)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
	Owner or Key-Man Insurance				21
	Special Legal Fees & Legal Retainers				22
	Malpractice Insurance for Individuals				23
24	Bad Debt	3,997	43		24
25	Fund Raising, Advertising and Promotional				25
	Income Taxes and Illinois Personal				
	Property Replacement Tax				26
	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	/3 // // //			28
	Other-Attach Schedule See Schedule 5A	(3,002)		1	29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (135,782)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

			1	2	
		An	ount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$			31
32	Donated Goods-Attach Schedule*				32
	Amortization of Organization &				
33	Pre-Operating Expense				33
	Adjustments for Related Organization				
34	Costs (Schedule VII)		69,157		34
35	Other- Attach Schedule				35
36	SUBTOTAL (B): (sum of lines 31-35)	\$	69,157		36
	(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$	(66,625)		37

<sup>\*</sup>These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

(See instructions.)

1 2 3

4	,					
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

48   49   50   51   52		OHF USE ONL	V				
	48		49	50	51	52	

# Briarbrook Place Provider # 0038232 June 30, 2001

# Schedule 5A

VI. Adjustment Detail Line 29 - Other

Non-allowable Expenses	Amount	Reference
Out of state travel Miscellaneous income offset Out of period professional fees	(903) (10) (2,089)	43 21 19
	(3,002)	:

#### STATE OF ILLINOIS

Page 5A

Briarbrook Place

ID#	0038232
Report Period Beginning:	07/01/00
Ending:	06/30/01

Sch. V Line

	NON-ALLOWABLE EXPENSES	Amount	Reference	
1		s		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
-	Total	0		49
7/	i Viui	1		77

Facility Name & ID Number Briarbrook Place # 0038232 Report Period Beginning: 07/01/00 Ending: 06/30/01

_	SUMMARY OF PAGES 5, 5A, 6, 6A	A, 6B, 6C, 6D,	6E, 6F, 6G, 6I	H AND 6I										
													SUMMARY	
	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col	.7)
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	64	0	0	0	0	0	0	64	5
6	Maintenance	0	36	0	0	983	0	0	0	0	0	0	1,019	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	36	0	0	1,047	0	0	0	0	0	0	1,083	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	- 0 00
11	Activities	0	0	0	0	1,702	0	0	0	0	0	0	1,702	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	1,702	0	0	0	0	0	0	1,702	16
	C. General Administration													
17	Administrative	0	1,923	0	57,000	(60,983)	0	0	0	0	0	0	(2,060)	17
18	Directors Fees	0	800	0	3,906	0	0	0	0	0	0	0	4,706	18
19	Professional Services	0	1,964	0	0	6,928	0	0	0	0	0	0	8,892	19
20	Fees, Subscriptions & Promotions	0	70	0	1,150	42	0	0	0	0	0	0	1,262	20
21	Clerical & General Office Expenses	0	5,912	0	564	3,716	2,606	0	0	0	0	0	12,798	21
22	Employee Benefits & Payroll Taxes	0	9,821	0	6,882	2,150	0	0	0	0	0	0	18,853	22
23	Inservice Training & Education	0	0	0	0	299	0	0	0	0	0	0	299	23
24	Travel and Seminar	0	713	0	257	968	0	0	0	0	0	0	1,938	
25	Other Admin. Staff Transportation	0	30	0	42	106	0	0	0	0	0	0	178	
26	Insurance-Prop.Liab.Malpractice	0	47	0	4,341	124	0	0	0	0	0	0	4,512	
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	
28	TOTAL General Administration	0	21,280	0	74,142	(46,650)	2,606	0	0	0	0	0	51,378	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	0	21,316	0	74,142	(43,901)	2,606	0	0	0	0	0	54,163	29

STATE OF ILLINOIS Summary B

Facility Name & ID Number Briarbrook Place # 0038232 Report Period Beginning: 07/01/00 Ending: 06/30/01

#### SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

													SUMMARY	
	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6 <b>G</b>	6H	6I	(to Sch V, col	.7)
30	Depreciation	0	311	0	0	258	18,250	0	0	0	0	0	18,819	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,804)	369	0	3,829	2,650	53,241	0	0	0	0	0	57,285	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	1,771	(66,873)	0	0	0	0	0	(65,102)	34
35	Rent-Equipment & Vehicles	0	0	0	0	807	0	0	0	0	0	0	807	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,804)	680	0	3,829	5,486	4,618	0	0	0	0	0	11,809	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	381	0	0	0	0	0	0	0	0	381	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(129,976)	0	0	0	0	0	0	0	0	0	0	(129,976)	43
44	TOTAL Special Cost Centers	(129,976)	0	381	0	0	0	0	0	0	0	0	(129,595)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(132,780)	21,996	381	77,971	(38,415)	7,224	0	0	0	0	0	(63,623)	45

# 0038232

Report Period Beginning:

07/01/00

**Ending:** 

06/30/01

#### VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

TI: Enter Belevi the number of AE	<u> </u>	iatea organizationo (partico) ao acimica n	T the motional fittaen	an additional conce	auto ii iioooooui ji			
1		2	3					
OWNERS		RELATED NURSING HO	OMES	OTHER REL	OTHER RELATED BUSINESS ENTITIES			
Name	Ownership %	Name	Name City Na			Type of Business		
Progressive Housing, Inc 100%		See attached Related Party Schedule		See attached Related	Party Schedule			
See attached Schedule 7A								

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

| X YES | NO |

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
1	V	6	Repairs & maintenance	\$	Center for Residential Management, Inc.	**	\$ 36	\$ 36	1
2	V	11	Activity programming		Center for Residential Management, Inc.	**			2
3	V	17	Management fees	6,247	Center for Residential Management, Inc.	**	8,170	1,923	3
4	V	18	Board fees		Center for Residential Management, Inc.	**	800	800	4
5	V	19	Professional fees		Center for Residential Management, Inc.	**	1,964	1,964	5
6	V	20	Licenses, dues & subscriptions		Center for Residential Management, Inc.	**	70	70	6
7	V	21	Office supplies & telephone		Center for Residential Management, Inc.	**	5,912	5,912	7
8	V	22	Emp. benefits & payroll taxes		Center for Residential Management, Inc.	**	9,821	9,821	8
9	V	24	Travel & seminar		Center for Residential Management, Inc.	**	713	713	9
10	V	25	Vehicle expense		Center for Residential Management, Inc.	**	30	30	10
11	V	26	Vehicle, fire & liab. insurance		Center for Residential Management, Inc.	**	47	47	11
12	V	30	Depreciation		Center for Residential Management, Inc.	**	311	311	12
13	V	32	Interest expense		Center for Residential Management, Inc.	**	369	369	13
14	Total			\$ 6,247			\$ 28,243	\$ * 21,996	14

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

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		STATE OF ILLINOIS		F	Page 6A	
Facility Name & ID Number	Briarbrook Place	# 0038232 Report Period Beginning:	07/01/00	Ending:	06/30/01	

#### VII. RELATED PARTIES (continued)

В.	Are any costs included in this report which are a result of transactions with	ı rela	ted organizati	ons?	This includes rent,
	management fees, purchase of supplies, and so forth.	X	YES		NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
					-	Percent	Operating Cost	Adjustments for
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization
						Ownership	Organization	Costs (7 minus 4)
15	V	39	Ancillary service centers	S	Center for Residential Management, Inc.	**		\$ 381 15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V				**Center for Residential Management, Inc. is			22
23	V				Progressive Housing, Inc.'s parent company.			23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V		_					38
39	Total			s			s 381	s * 381 39

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

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Page 6B # 0038232 Facility Name & ID Number **Briarbrook Place** Report Period Beginning: 07/01/00 **Ending:** 06/30/01

#### VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, x YES NO management fees, purchase of supplies, and so forth.

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Scho	dule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	i
						Ownership	Organization	Costs (7 minus 4)	
15	V	17	Management fees	\$	Progressive Housing, Inc.	100.00%	\$ 57,000	\$ 57,000	15
16	V	18	Board fees		Progressive Housing, Inc.	100.00%	3,906	3,906	
17	V	20	Licenses, dues & subscriptions		Progressive Housing, Inc.	100.00%	1,150	1,150	17
18	V	21	Office supplies & telephone		Progressive Housing, Inc.	100.00%	564	564	18
19	V	22	Emp. benefits & payroll taxes		Progressive Housing, Inc.	100.00%	6,882	6,882	19
20	V	24	Travel & seminar		Progressive Housing, Inc.	100.00%	257	257	20
21	V	25	Vehicle expense		Progressive Housing, Inc.	100.00%	42	42	21
22	V	26	Vehicle, fire & liab. insurance		Progressive Housing, Inc.	100.00%	4,341		22
23	V	32	Interest expense		Progressive Housing, Inc.	100.00%	3,829	3,829	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			s 77,971	s * 77,971	39

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

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Page 6C # 0038232 Facility Name & ID Number **Briarbrook Place** Report Period Beginning: 07/01/00 **Ending:** 06/30/01

#### VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, x YES NO management fees, purchase of supplies, and so forth.

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sch	dule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
					C	Ownership	Organization	Costs (7 minus 4)	
15	V	5	Utilities	\$	Developmental Services of Illinois, Inc.	**	\$ 64	\$ 64 1	15
16	V	6	Repairs & maintenance		Developmental Services of Illinois, Inc.	**	983	983 10	16
17	V	11	Activity programming		Developmental Services of Illinois, Inc.	**	1,702	1,702 1	17
18	V	17	Management fees	60,983	Developmental Services of Illinois, Inc.	**		(60,983) 18	18
19	V	19	Professional fees		Developmental Services of Illinois, Inc.	**	6,928	6,928 19	19
20	V	20	Licenses, dues & subscriptions		Developmental Services of Illinois, Inc.	**	42	42   20	20
21	V	21	Office supplies & telephone		Developmental Services of Illinois, Inc.	**	3,716	3,716 2	21
22	V	22	Emp. benefits & payroll taxes		Developmental Services of Illinois, Inc.	**	2,150	2,150 22	22
23	V		Inservice education		Developmental Services of Illinois, Inc.	**	299	299 23	23
24	V	24	Travel & seminar		Developmental Services of Illinois, Inc.	**	968	968 24	24
25	V	25	Vehicle expense		Developmental Services of Illinois, Inc.	**	106	106 2:	25
26	V	26	Vehicle, fire & liab. insurance		Developmental Services of Illinois, Inc.	**	124	124 20	26
27	V	30	Depreciation		Developmental Services of Illinois, Inc.	**	258	258 2'	27
28	V	32	Interest expense		Developmental Services of Illinois, Inc.	**	2,650	2,650 28	28
29	V	34	Rent expense		Developmental Services of Illinois, Inc.	**	1,771	1,771 29	29
30	V	35	Equipment rental		Developmental Services of Illinois, Inc.	**	807	807 30	30
31	V							3:	31
32	V							32	32
33	V							33	33
34	V							34	34
35	V				**Developmental Services of Illinois, Inc. is			35	35
36	V				Progressive Housing, Inc.'s management company.			30	36
37	V							3'	37
38	V						_	38	38
39	Total			s 60,983			s 22,568	\$ * (38,415) 39	39

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

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		STATE OF ILLINOIS				I	Page 6D
Facility Name & ID Number	Briarbrook Place	# 0038	8232	Report Period Beginning:	07/01/00	Ending:	06/30/01

#### VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, x YES NO management fees, purchase of supplies, and so forth.

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Scho	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	Į.
						Ownership	Organization	Costs (7 minus 4)	
15	V	21	Office supplies & telephone	\$	Residential Centers, Inc.	**	\$ 2,606		15
16	V	30	Depreciation		Residential Centers, Inc.	**	18,250	18,250	16
17	V	32	Interest expense		Residential Centers, Inc.	**	53,241	53,241	17
18	V	34	Rent expense	66,873	Residential Centers, Inc.	**		(66,873)	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V				**Residential Centers, Inc. is Progressive				23
24	V				Housing, Inc.'s sister company.				24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 66,873			\$ 74,097	s * 7,224	39

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

# Schedule VII - Related Parties Page 6, Section A, Column 2, Related Nursing Homes

### **Related Party Schedule**

Name	Facility Name	City
Dragragiya Hayaing Inc	Gateway Terrace	Impirator
Progressive Housing, Inc.	Aviston Terrace	Irvington Aviston
	Briarbrook Place	East Peoria
	Joshua Manor	Hoyleton
	Terra Estates	Hoyleton
	Park Place	Pana
	Harris Place	East Peoria
	Okawville	Okawville
	Billy Goat Hill	Mt. Vernon
	Country Club Hills	Country Club Hills
	Galaxy	Woodlawn
	Perrine	Centralia
	Troy	Troy
	Western Gardens	Mt. Vernon
	Cardinal	Woodlawn
Residential Centers, Inc.	Lakeview Living Center	Chicago
	Countryview Living Center	Latham
	Sparta Terrace	Sparta
	Taylorville Terrace	Taylorville
	Ellner Terrace	Evansville
Caravilla Resident Centers, Inc.	Mt. Vernon Care Center	Mt. Vernon
	Jeffersonian Care Center	Mt. Vernon
	Casey Care Center	Mt. Vernon
Schedule VII, Related Parties		
Page 6, Section A, Column 3, Other Rel	ated Business Entities	
Name	City	Type of Business
Center for Residential Management, Inc.	Peoria	Management/Holding Co.
Residential Centers, Inc.	Peoria	ICF/DD Provider
Progressive Housing, Inc.	Peoria	ICF/DD Provider
Caravilla Charitable Corporation	Mt. Vernon	Lessor
Caravilla Resident Centers, Inc.	Mt. Vernon	SNF/ICF Provider
Developmental Services of Illinois, Inc.	Peoria	Management Co.

Facility Name & ID Number Briarbrook Place # 0038232 Report Period Beginning: 07/01/00 Ending: 06/30/01

#### VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5		6	7	8		
						Average Hou	ırs Per Work				
					Compensation	Week Dev	oted to this	Compensation	on Included	Schedule V.	
					Received	Facility and	l % of Total	in Costs	for this	Line &	
				Ownership	From Other	Work	Week	Reportin	g Period**	Column	
	Name	Title	Function	Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Darrell Boehne	President	<b>Board Member</b>	None	13,981	2 hrs/mtg.		<b>Directors Fees</b>	<b>819</b>	L18, C8	1
2	<b>Edward Childers</b>	Vice President	<b>Board Member</b>	None	13,893	2 hrs/mtg.		<b>Directors Fees</b>	707	L18, C8	2
3	Ronald Schroeder	Secretary	<b>Board Member</b>	None	14,122	2 hrs/mtg.		<b>Directors Fees</b>	678	L18, C8	3
4	Kay Schuman Johnson	Treasurer	<b>Board Member</b>	None	3,529	2 hrs/mtg.		<b>Directors Fees</b>	471	L18, C8	4
5	Cora Flota	Director	<b>Board Member</b>	None	3,529	2 hrs/mtg.		<b>Directors Fees</b>	471	L18, C8	5
6	Merla McCloud	Recorder	Administrative	None	17,722	2 hrs/mtg.		<b>Directors Fees</b>	678	L18, C8	6
7	Orland Bauer	Director	<b>Board Member</b>	None	8,119	2 hrs/mtg.		<b>Directors Fees</b>	681	L18, C8	7
8	Robert Bauer	Director	<b>Board Member</b>	None	14,687	2 hrs/mtg.		<b>Directors Fees</b>	113	L18, C8	8
9	Eugene Humphrey	Director	<b>Board Member</b>	None	4,732	2 hrs/mtg.		<b>Directors Fees</b>	68	L18, C8	9
10	<b>Duane Satterwhite</b>	Director	<b>Board Member</b>	None	4,780	2 hrs/mtg.		<b>Directors Fees</b>	20	L18, C8	10
11											11
12	See attached Schedule 7A										12
13								TOTAL	\$ 4,706		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).

FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Briarbrook Place # 0038232 Report Period Beginning: 07/01/00 Ending: 06/30/01

#### VIII. ALLOCATION OF INDIRECT COSTS

	Name of Related Organization	Center for Residential Management, Inc.
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	4239 W. War Memorial Dr., Suite 302
or parent organization costs? (See instructions.)  YES x  NO	City / State / Zip Code	Peoria, IL 61614
<del></del>	Phone Number	( 309) 685-0595
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	( 309) 685-8463
¥ : A		

	1	2	3	4	5	6	7	8	9	$\Box$
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	6	Repairs & maintenance	Bed days available	205,860	20	\$ 1,284	\$	5,840	\$ 36	1
2	17	Management fees	Bed days available	205,860	20	288,000		5,840	8,170	2
3	18	Board fees	Bed days available	205,860	20	28,200		5,840	800	3
4	19	Professional fees	Bed days available	205,860	20	69,236		5,840	1,964	4
5	20	Licenses, dues & subscriptions	Bed days available	205,860	20	270		5,840	7	5
6	21	Office supplies & telephone	Bed days available	205,860	20	18,491		5,840	525	6
7	22	Emp. benefits & payroll taxes	Bed days available	205,860	20	41,807		5,840	1,186	7
8	24	Travel & seminar	Bed days available	205,860	20	13,361		5,840	380	8
9	25	Vehicle expense	Bed days available	205,860	20	1,044		5,840	30	9
10	26	Vehicle, fire & liab. insurance	Bed days available	205,860	20	1,644		5,840	47	10
11	30	Depreciation	Bed days available	205,860	20	10,967		5,840	311	11
12	32	Interest expense	Bed days available	205,860	20	13,013		5,840	369	12
13	39	Ancillary service centers	Bed days available	205,860	20	13,408		5,840	381	13
14										14
15										15
16										16
17	20	Licenses, dues & subscriptions	Direct method						63	17
18	21	Office supplies & telephone	Direct method						5,387	18
19	22	Emp. benefits & payroll taxes	Direct method						8,635	19
20	24	Travel & seminar	Direct method						333	20
21										21
22										22
23	•				_				_	23
24		·								24
25	TOTALS					\$ 500,725	\$		\$ 28,624	25

#### VIII. ALLOCATION OF INDIRECT COSTS

	Name of Related Organization	Progressive Housing, Inc.
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	4239 W. War Memorial Dr., Suite 302
or parent organization costs? (See instructions.)  YES x  NO	City / State / Zip Code	Peoria, IL 61614
<del>-</del>	Phone Number	( 309) 685-0595
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	( 309) 685-8463

	1	2	3	4	5		6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total	l Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		<b>Subunits Being</b>	Cos	st Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	<b>Total Units</b>	Allocated Among	All	located	in Column 6	Units	(col.8/col.4)x col.6	
1	17	Management fees	Number of beds	136	13	\$	409,550	\$	16	\$ 57,000	1
2	18	Board fees	Number of beds	136	13		33,200		16	3,906	2
3	20	Licenses, dues & subscriptions	Number of beds	136	13		9,775		16	1,150	3
4	21	Office supplies & telephone	Number of beds	136	13		4,793		16	564	4
5	22	Emp. benefits & payroll taxes	Number of beds	136	13		(162)		16	(21)	5
6	24	Travel & seminar	Number of beds	136	13		2,263		16	257	6
7	25	Vehicle expense	Number of beds	136	13		356		16	42	7
8	32	Interest expense	Number of beds	136	13		32,547		16	3,829	8
9											9
10											10
11											11
12			Direct method							6,903	12
13	26	Vehicle, fire & liab. insurance	Direct method							4,341	13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25	TOTALS					\$	492,322	\$		\$ 77,971	25

# 0038232 Report Period Beginning:

STATE OF ILLINOIS Page 8B

07/01/00

Ending: 06/30/01

۲	71	П	n	ſ	4	۸.	T	I	n	•	٦ /	١,	$\Gamma$	1	1	N	I (	n	H	1	N	П	ì	L	21	E)	$C^{r}$	г	C	n	S	т	١,ς	

Facility Name & ID Number Briarbrook Place

MICHEE CENTION OF INDIRECT COSTS		
	Name of Related Organization	Developmental Services of Illinois, Inc.
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	4239 W. War Memorial Dr., Suite 302
or parent organization costs? (See instructions.)  YES x  NO	City / State / Zip Code	Peoria, IL 61614
	Phone Number	( 309) 685-0595
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	( 309) 685-8463

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	5	Utilities	Bed days available	205,860	20	\$ 2,273	\$	5,840	\$ 64	1
2	6	Repairs & maintenance	Bed days available	205,860	20	34,653		5,840	983	2
3	11	Activity programming	Bed days available	205,860	20	60,000		5,840	1,702	3
4	19	Professional fees	Bed days available	205,860	20	244,200		5,840	6,928	4
5	20	Licenses, dues & subscriptions	Bed days available	205,860	20	1,464		5,840	42	5
6	21	Office supplies & telephone	Bed days available	205,860	20	130,977		5,840	3,716	6
7	22	Emp. benefits & payroll taxes	Bed days available	205,860	20	75,816		5,840	2,150	7
8	23	Inservice education	Bed days available	205,860	20	10,547		5,840	299	8
9	24	Travel & seminar	Bed days available	205,860	20	34,127		5,840	968	9
10	25	Vehicle expense	Bed days available	205,860	20	3,724		5,840	106	10
11	26	Vehicle, fire & liab. insurance	Bed days available	205,860	20	4,401		5,840	124	11
12	30	Depreciation	Bed days available	205,860	20	9,100		5,840	258	12
13	32	Interest expense	Bed days available	205,860	20	93,395		5,840	2,650	13
14	34	Rent expense	Bed days available	205,860	20	62,438		5,840	1,771	14
15	35	Equipment rental	Bed days available	205,860	20	28,457		5,840	807	15
16										16
17										17
18										18
19										19
20										20
21	•			_				_		21
22				_						22
23										23
24										24
25	TOTALS					\$ 795,572	\$		\$ 22,568	25

#### IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5		6	7	8	9	10	
	Name of Lender	Relate YES	ed** NO	Purpose of Loan	Monthly Payment Required	Date of Note		Amou Original	nt of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related										, ,		
	Long-Term												
1	Lease Obligation-NCS		X	Hardware/software	\$94.00	10/31/98	\$	3,756		09/30/03	0.1429	\$ 247	1
	BankOne-Bond		X	Acquisition of facility	Varies	06/25/98		2,584,836	811,335	07/01/19	Varies	51,321	2
3	<b>Great American Leasing Corp.</b>		X	Copier	\$110.00	02/01/00		2,962	1,779	01/31/03	0.1987	625	3
4													4
5									Amortization of	f bond expe	nse	1,920	5
	Working Capital												
6	<b>Community Bank of Galesburg</b>		X	Working Capital	None	08/23/01		286,000	27,765	02/23/02	0.1000	3,280	
7													7
8													8
9	TOTAL Facility Related				\$204.00		\$	2,877,554	\$ 842,492			\$ 57,393	9
- 10	B. Non-Facility Related*					T	_				T		10
10									Miscellaneous			2,619	
11									Interest income			(109	/
12									Nonallowable f			(2,695	
13							_		Parent & mana	agement co.	allocation	3,019	13
14	TOTAL Non-Facility Related						\$		\$			\$ 2,834	1 14
15	TOTALS (line 9+line14)						\$	2,877,554	\$ 842,492			\$ 60,227	15

<sup>\*</sup> Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

<sup>\*\*</sup> If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

STATE OF ILLINOIS Page 10
# 0038232 Report Period Beginning: 07/01/00 Ending: 06/30/01

Facility Name & ID Number Briarbrook Place

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes						
	Important, please see the next workshee	et, "RE_Tax". The rea	estate tax statement and			
Real Estate Tax accrual used on 2000 report.	bill must accompany the cost report.			\$	2,065	1
2. Real Estate Taxes paid during the year: (Indicate the t	ax year to which this payment applies. If payment of	covers more than one year,	detail below.)	1999 \$	2,065	2
3. Under or (over) accrual (line 2 minus line 1).				s		3
4. Real Estate Tax accrual used for 2001 report. (Detail	and explain your calculation of this accrual on the	lines below.)		\$		4
5. Direct costs of an appeal of tax assessments which has (Describe appeal cost below. Attach copies	•			\$		5
6. Subtract a refund of real estate taxes. You must offse classified as a real estate tax cost plus one-half of any TOTAL REFUND \$ For 19	3 11	real estate tax appea	l board's decision.)	s		6
7. Real Estate Tax expense reported on Schedule V, line	33. This should be a combination of lines 3 thru 6			s		7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year: 1996	8,664 8		FOR OHF USE ONLY			
1997 1998	8,155 9 9,155 10	13	FROM R. E. TAX STATEMENT FO	OR 2000 \$		13
1999 2000	10,087 11 12	14	PLUS APPEAL COST FROM LINI	E5 \$		14
NOTE: For the 1999 assessment year, the state has approv		15	LESS REFUND FROM LINE 6	\$		15
the year 2000 and forward, Briarbrook will be 100% exem	ot from paying real estate taxes.	16	AMOUNT TO USE FOR RATE CA	ALCULATION\$		16

#### NOTES:

- 1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
- If facility is a non-profit which pays real estate taxes, you must attach a denial of an
  application for real estate tax exemption unless the building is rented from a for-profit entity.
  This denial must be no more than four years old at the time the cost report is filed.

#### IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

#### 2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FAC	ILITY NAME	Briarbrook Place			CC	OUNTY	Tazewell	
FAC	ILITY IDPH LIC	ENSE NUMBER	0038232					
CON	TACT PERSON	REGARDING TH	IS REPORTRob Keime					
TEL	EPHONE (309) 6	85-0595		FAX #:	(309) 685-846	3		
A.	Summary of Re	al Estate Tax Cos						
	cost that applies home property w	to the operation of hich is vacant, ren	I estate tax assessed for a the nursing home in Co ted to other organization de cost for any period of	lumn D. is, or used	Real estate tax a I for purposes o	applicable ther than	e to any poi	rtion of the nursir
	(A	)	<b>(B)</b>			(C)		(D) <u>Tax</u> Applicable to
	Tax Index	Number	Property Descrip	otion	To	otal Tax		Nursing Home
1.					\$		\$	
2.					\$			
3.					\$		_ \$	
4.					S		_ \$	
5.					S		_ \$	
6.	N/A				\$		_ \$	
7.					\$		_ \$	
8.								
9.								
10.					s		_ \$	
			1	TOTALS	s		= \$	
B.	Real Estate Tax	Cost Allocations						
		of the tax bill app home services:	ly to more than one nurs	sing home		ty, or pro	perty which	n is not direct
			chedule which shows th					

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which

C. Tax Bills

is normally paid during 2001.

Page 10A

				STATE OF ILLING	OIS				Page 11
	ity Name & ID Number Briarbrook			# 0038232	2 Report Peri	iod Beginning:	07/0	1/00 Ending:	06/30/01
X. B	UILDING AND GENERAL INFOR	MATION:							
A.	Square Feet: 4,1	B. General Construction Type:	Exterior	Brick	Frame	Wood	Number o	of Stories	One
C.	Does the Operating Entity?	(a) Own the Facility	x (b) Rent from	n a Related Organizat	ion.		(c) Rent from Organizat	n Completely Unr	related
	(Facilities checking (a) or (b) mus	t complete Schedule XI. Those checking (c	) may complete Sched	ule XI or Schedule XI	II-A. See instruc	ctions.	Organizat	ion.	
D.	Does the Operating Entity?	x (a) Own the Equipment	x (b) Rent equi	pment from a Related	l Organization.			pment from Com Organization.	ıpletely
	(Facilities checking (a) or (b) mus	t complete Schedule XI-C. Those checking	(c) may complete Sch	edule XI-C or Schedu	ıle XII-B. See in	structions.	Officiated	Organization.	
Е.	(such as, but not limited to, aparts	ned by this operating entity or related to th ments, assisted living facilities, day training , square footage, and number of beds/units	g facilities, day care, i	ndependent living fac	•				
	None								
F.	Does this cost report reflect any o If so, please complete the followin	rganization or pre-operating costs which a	re being amortized?			YES	x NO		
1.	. Total Amount Incurred:	N/A		2. Number of Years	Over Which it	is Being Amor	tized:	N/A	
3.	Current Period Amortization:	<u>N/A</u>		4. Dates Incurred:	1	N/A			
		Nature of Costs: (Attach a complete schedule deta	ailing the total amoun	t of organization and	pre-operating c	osts.)			
XI. C	OWNERSHIP COSTS:	1	2	3		4			

Square Feet

47,250

47,250

Use

Resident use

1 Resid 2 3 TOTALS

A. Land.

SEE ACCOUNTANTS' COMPILATION REPORT

Year Acquired

1999 \$

Cost

20,000

20,000

2

STATE OF ILLINOIS

Page 12 06/30/01 Facility Name & ID Number Briarbrook Place # 0038

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment, (See instructions.) Round all numbers to nearest dollar # 0038232 Report Period Beginning: 07/01/00 Ending:

	B. Buildii	ng Depreciation-Including Fixed Equ	uipment. (See inst		id all numbers to nea						
	1		2	3	4	5	6	7	8	9	
		FOR OHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4	16		1999	1991	\$ 730,000	\$	40	\$ 18,250		\$ 42,584	4
5											5
6											6
7											7
8											8
	Impro	vement Type**									
9	Landscaping			1994	1,593	106	15	106		795	9
	Carpeting			1999	1,728	115	15	115		288	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24 25											24 25
26											26
27											27
28							1				28
29							1				29
30						<b> </b>					30
31						<b> </b>					31
32											32
33							<del> </del>				33
34							<del> </del>				34
35							<del>                                     </del>	+			35
36											36
20				l	l	1	1				

See Page 12A, Line 70 for total SEE ACCOUNTANTS' COMPILATION REPORT

<sup>\*</sup>Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete

I	uipment. (See instructions.) Roui 3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8	Accumulated	
Improvement Type**	Constructed	S	S	III Tears	Depreciation	Adjustments	Depreciation 8	37
38		3	3		3	3	3	38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		s 733,321	\$ 221		s 18,471	\$ 18,250	\$ 43,667	70

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete

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Page 13 # 0038232 07/01/00 06/30/01 Facility Name & ID Number **Briarbrook Place** Report Period Beginning: **Ending:** 

#### XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	C. Equipment Depreciation-Excluding 11 ansportation, (see instructions.)										
	Category of	1		Current Book	Straight Line	4	Component	Accumulated			
	Equipment	Cost		Depreciation 2	Depreciation 3	Adjustments	Life 5	Depreciation 6			
71	Purchased in Prior Years	\$ 23,103	\$	2,605	\$ 2,605	\$	5-10 Years	\$ 10,750	71		
72	Current Year Purchases								72		
73	Fully Depreciated Assets								73		
74	Parent and management compan	y allocation			569	569			74		
75	TOTALS	\$ 23,103	\$	2,605	\$ 3,174	\$ 569		\$ 10,750	75		

#### D. Vehicle Depreciation (See instructions.)\*

	1	Model, Make	Year	4	Current Book	Straight Line	7	Life in	Accumulated	
	Use	and Year 2	Acquired 3	Cost	Depreciation 5	Depreciation 6	Adjustments	Years 8	Depreciation 9	
76	Resident Care	Wheelchair lift on	1992	\$ 3,338	\$	\$	\$	3	\$ 3,338	76
77		leased van								77
78										78
79										79
80	TOTALS			\$ 3,338	\$	\$	\$		\$ 3,338	80

#### E. Summary of Care-Related Assets

	E. Summary of Care-Related Assets	1	2		
		Reference	Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 779,7	62 8	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 2,8	26 8	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 21,6	45 8	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 18,8	19 8	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 57,7	55 8	85

#### F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1	2	Current Book	Accumulated	
	Description & Year Acquired	Cost	Depreciation 3	Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

#### G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

SEE ACCOUNTANTS' COMPILATION REPORT

<sup>\*\*</sup> This must agree with Schedule V line 30, column 8.

800.00

20

21 TOTAL

SEE ACCOUNTANTS' COMPILATION REPORT

9,600

20

21

\*\* This amount plus any amortization of lease

expense must agree with page 4, line 34.

Facility Name & ID Number Briarbrook Place				#	0038232	Report Period Begi	nning: 07/01	/00 Ending:	06/30/01
XIII. EXPENSES RELATING TO NURSE AIDE TRAINI	NG PROGRAMS (	See instructions.)							
A. TYPE OF TRAINING PROGRAM (If aides are tr	ained in another fac	cility program, attach a	schedule listing t	he facility	name, addre	ss and cost per aide tr	ained in that facilit	y.)	
1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? It is the policy of this facility to only hire certified nurses aides If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	YES X NO	2. CLASSROOM IN-HOUSE PI IN OTHER FA COMMUNITY HOURS PER	ROGRAM ACILITY Y COLLEGE			IN-He IN O	ICAL PORTION: OUSE PROGRAM THER FACILITY RS PER AIDE		
B. EXPENSES	ALLO	CATION OF COSTS	(d)				CTUAL INCOME	the emount of it	
	1	2	3		4		y received training		
		Facility							
	Drop-o	uts Completed	Contract		Total	\$			
1 Community College Tuition	\$	\$	\$	\$					
2 Books and Supplies						D. NUMBER	OF AIDES TRAIN	ED	
3 Classroom Wages (a)									
4 Clinical Wages (b)							OMPLETED		
5 In-House Trainer Wages (c)							m this facility		
6 Transportation							om other facilities	(f)	
7 Contractual Payments							ROP-OUTS		
8 Nurse Aide Competency Tests							m this facility		
9 TOTALS	<b> \$</b>	<b> \$</b>	\$	\$		2. Fro	m other facilities	(f)	

STATE OF ILLINOIS

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.

(e)

10 SUM OF line 9, col. 1 and 2

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

TOTAL TRAINED

Page 15

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Page 16 07/01/00 Ending: 06/30/01

#### XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	, ,	1	2	3	4	5	6	7	8	
		Schedule V	Stafi	i	Outside Practitioner		Supplies			
	Service	Line & Column	Units of	Cost	(other th	an consultant)	(Actual or)	<b>Total Units</b>	<b>Total Cost</b>	
		Reference	Service		Units	Cost	Allocated)	(Column 2 + 4)	(Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	\$		\$	\$		<b>S</b>	1
	Licensed Speech and Language									
2	Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
			# of							
9	Pharmacy		prescrpts							9
	Psychological Services									
	(Evaluation and Diagnosis/									
10	Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Schedule 16a				3	495	381	3	876	13
14	TOTAL			\$	3	\$ 495	\$ 381	3	876	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

# Briarbrook Place Provider # 0038232 June 30, 2001

# Schedule 16A

XIV. Special Services Line 13 - Other

	Line &			
Service	Col. Ref.	Units	Cost	Supplies
Emergency Dental Eye Care	L39, C3 L39, C3	1 2	340 155	
Part B Medicare Supplies	L39, C8			381
	=	3	495	381

		10	Operating Consolidation*			
	A. Current Assets					
1	Cash on Hand and in Banks	\$	372	\$	372	1
2	Cash-Patient Deposits					2
	Accounts & Short-Term Notes Receivable-					
3	Patients (less allowance 3,404)		109,760		109,760	3
4	Supply Inventory (priced at )					4
5	Short-Term Investments					5
6	Prepaid Insurance		2,256		2,256	6
7	Other Prepaid Expenses		21,755		21,755	7
8	Accounts Receivable (owners or related parties)		701,178		701,178	8
9	Other(specify): Prepaid Deposit		720		720	9
	TOTAL Current Assets					
10	(sum of lines 1 thru 9)	\$	836,041	\$	836,041	10
	B. Long-Term Assets					
11	Long-Term Notes Receivable					11
12	Long-Term Investments					12
13	Land				20,000	13
14	Buildings, at Historical Cost		3,321		733,321	14
15	Leasehold Improvements, at Historical Cost					15
16	Equipment, at Historical Cost		26,441		26,441	16
17	Accumulated Depreciation (book methods)		(15,171)		(57,755)	17
18	Deferred Charges					18
19	Organization & Pre-Operating Costs					19
	Accumulated Amortization -					
20	Organization & Pre-Operating Costs					20
21	Restricted Funds					21
22	Other Long-Term Assets (specify):					22
23	Other(specify): Unamortized Bond Fees				36,005	23
	TOTAL Long-Term Assets					
24	(sum of lines 11 thru 23)	\$	14,591	\$	758,012	24
	TOTAL ASSETS					
25	(sum of lines 10 and 24)	\$	850,632	\$	1,594,053	25

		1 On	erating	1	2 After	
	C. Current Liabilities		<u>.</u>	Ì		
26	Accounts Payable	\$	63,278	\$	63,278	26
27	Officer's Accounts Payable					27
28	Accounts Payable-Patient Deposits					28
29	Short-Term Notes Payable		45,185		45,185	29
30	Accrued Salaries Payable		12,175		12,175	30
	Accrued Taxes Payable					
31	(excluding real estate taxes)					31
32	Accrued Real Estate Taxes(Sch.IX-B)					32
33	Accrued Interest Payable					33
34	Deferred Compensation					34
35	Federal and State Income Taxes					35
	Other Current Liabilities(specify):					
36	See Schedule 17A		18,059		18,059	36
37						37
	TOTAL Current Liabilities					
38	(sum of lines 26 thru 37)	\$	138,697	\$	138,697	38
	D. Long-Term Liabilities					
39	Long-Term Notes Payable		3,392		3,392	39
40	Mortgage Payable					40
41	Bonds Payable				793,915	41
42	Deferred Compensation					42
	Other Long-Term Liabilities(specify):					
43						43
44						44
	TOTAL Long-Term Liabilities					
45	(sum of lines 39 thru 44)	\$	3,392	\$	797,307	45
	TOTAL LIABILITIES					
46	(sum of lines 38 and 45)	\$	142,089	\$	936,004	46
47	TOTAL EQUITY(page 18, line 24)	\$	708,543	\$	658,049	47
1	TOTAL LIABILITIES AND EQUITY					
48	(sum of lines 46 and 47)	\$	850,632	\$	1,594,053	48

07/01/00

**Ending:** 

Page 17 06/30/01

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

# Briarbrook Place Provider # 0038232 June 30, 2001

# Schedule 17A

XV. Balance Sheet Line 36 - Other

Accrued Legal & Accounting	Operating	After Consolidation
Accrued Expense	2,773	2,773
Accrued Legal & Accounting	68	68
Accrued Workshop	13,833	13,833
Resident Credit Balances	1,385	1,385
	18,059	18,059

**See Accountants' Compilation Report** 

)F CF	HANGES IN EQUITY				
			1 Total		
1	Balance at Beginning of Year, as Previously Reported	s	566,900	1	-
2	Restatements (describe):	Ψ	200,200	2	-
3	Prior period audit adjustment - allowance for doubtful		3,404	3	
4	accounts			4	1
5				5	1
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	570,304	6	
	A. Additions (deductions):				
7	NET Income (Loss) (from page 19, line 43)		230,628	7	1
8	Aquisitions of Pooled Companies			8	
9	Proceeds from Sale of Stock			9	
10	Stock Options Exercised			10	
11	Contributions and Grants			11	
12	Expenditures for Specific Purposes			12	
13	Dividends Paid or Other Distributions to Owners	(	)	13	
14	Donated Property, Plant, and Equipment			14	
15	Other (describe) Parent and management company			15	
16	Other (describe) allocations added back in column 7		(92,389)	16	I
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$	138,239	17	
	B. Transfers (Itemize):				
18				18	
19				19	
20				20	
21				21	
22				22	
23	TOTAL Transfers (sum of lines 18-22)	\$		23	
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$	708,543	24	*

Operating entity only
\* This must agree with page 17, line 47.

**Ending:** 

# 0038232 **Report Period Beginning:** XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached. Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue All Levels of Care	\$ 659,980	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 659,980	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education	133,451	9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	3,186	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 136,637	23
	D. Non-Operating Revenue	· · ·	
24	Contributions		24
25	Interest and Other Investment Income***	109	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 109	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	10	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 10	29
	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 796,736	30

		2	
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	85,782	31
32	Health Care	138,822	32
33	General Administration	91,540	33
	B. Capital Expense		
34	Ownership	82,494	34
	C. Ancillary Expense		
35	Special Cost Centers	131,374	35
36	Provider Participation Fee	36,096	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 566,108	40
	,		
41	Income before Income Taxes (line 30 minus line 40)**	230,628	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 230,628	43

This must agree with page 4, line 45, column 4.

Does this agree with taxable income (loss) per Federal Income No If not, please attach a reconciliation. Tax Return? A federal tax return is filed for the combined divisions of Progressive Housing, Inc.

<sup>\*\*\*</sup> See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a SEE ACCOUNTANTS' COMPILATION REPORT detailed explanation.

<sup>\*\*\*\*</sup>Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Briarbrook Place

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4				
	# of Hrs.	# of Hrs.	Reporting Period	Average				N
	Actually	Paid and	Total Salaries,	Hourly				0
	Worked	Accrued	Wages	Wage				P
1 Director of Nursing			\$	\$	1	1		A
2 Assistant Director of Nursing					2	35	Dietary Consultant	
3 Registered Nurses	51	51	1,037	20.33	3	36	Medical Director	Mo
4 Licensed Practical Nurses					4	37	Medical Records Consultant	
5 Nurse Aides & Orderlies					5	38	Nurse Consultant	
6 Nurse Aide Trainees					6	39	Pharmacist Consultant	Mo
7 Licensed Therapist					7	40	Physical Therapy Consultant	
8 Rehab/Therapy Aides					8	41	Occupational Therapy Consultant	
9 Activity Director					9	42	Respiratory Therapy Consultant	
10 Activity Assistants					10	43	Speech Therapy Consultant	
11 Social Service Workers					11	44	Activity Consultant	
12 Dietician					12	45	Social Service Consultant	
13 Food Service Supervisor					13	46	Other(specify) Psychological	Mo
14 Head Cook	2,152	2,282	18,346	8.04	14	47		
15 Cook Helpers/Assistants		ĺ	, and the second		15	48		
16 Dishwashers					16			
17 Maintenance Workers	1,001	1,014	10,003	9.86	17	49	TOTAL (lines 35 - 48)	
18 Housekeepers					18			
19 Laundry					19			
20 Administrator	1,872	2,060	31,801	15.44	20			
21 Assistant Administrator					21	C. 0	CONTRACT NURSES	
22 Other Administrative	296	311	7,102	22.84	22			
23 Office Manager					23			N
24 Clerical	633	656	14,138	21.55	24	1		0
25 Vocational Instruction					25	1		P
26 Academic Instruction					26	1		A
27 Medical Director					27	50	Registered Nurses	
28 Qualified MR Prof. (QMRP)					28	51	Licensed Practical Nurses	
29 Resident Services Coordinator					29	52	Nurse Aides	
30 Habilitation Aides (DD Homes)	14,133	15,165	119,728	7.90	30			
31 Medical Records	<u> </u>		, -		31	53	TOTAL (lines 50 - 52)	
32 Other Health Care(specify)					32			
33 Other(specify)					33	1		
34 TOTAL (lines 1 - 33)	20,138	21,539	s 202,155 *	s 9.39	34	SEE AC	COUNTANTS' COMPILATION RE	PORT

#### B. CONSULTANT SERVICES

		1	2	3	
		Number	<b>Total Consultant</b>	Schedule V	
		of Hrs.	Cost for	Line &	
		Paid &	Reporting	Column	
		Accrued	Period	Reference	
35	Dietary Consultant	32	\$ 1,731	L1,C3	35
36	Medical Director	Monthly	660	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	164	L10,C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	8	310	L10A,C3	43
44	Activity Consultant	12	1,702	L11, C8	44
45	Social Service Consultant	3	365	L12,C3	45
46	Other(specify) Psychological	Monthly	2,405	L10,C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	55	s 7,337		49

#### C. CONTRACT NURSES

		1	2	3	
		Number		Schedule V	
		of Hrs.	Total	Line &	
		Paid &	Contract	Column	
		Accrued	Wages	Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53
33	1017tE (mics 30 - 32)		Φ		33

<sup>\*</sup> This total must agree with page 4, column 1, line 45.

<sup>\*\*</sup> See instructions.

STATE	OF	TTT	INIO	TC
SIAIL	Uľ	ILL	AINO	12

Page 21

Facility Name & ID Number # 0038232 Report Period Beginning: 07/01/00 06/30/01 **Briarbrook Place** Ending: XIX. SUPPORT SCHEDULES A. Administrative Salaries Ownership D. Employee Benefits and Payroll Taxes F. Dues, Fees, Subscriptions and Promotions Description Description Name **Function** Amount Amount Amount **IDPH License Fee** Danette Bezik Administrator 31,801 Workers' Compensation Insurance 6,958 **Unemployment Compensation Insurance** 1,813 Advertising: Employee Recruitment 988 7,102 15,465 Health Care Worker Background Check Parent Company Allocation See Schedule 21A FICA Taxes **Employee Health Insurance** 5,481 (Indicate # of checks performed 63 **Employee Meals** 3,060 Illinois Health Care Association 794 Illinois Municipal Retirement Fund (IMRF)\* Various Subscriptions 1,693 **Other Employee Benefits** 1,401 Various License & Fees 80 TOTAL (agree to Schedule V, line 17, col. 1) **Employee Physicals** 120 Management & Parent Co. Allocations 45 (List each licensed administrator separately.) 38,903 B. Administrative - Other Less: Public Relations Expense Description Non-allowable advertising Amount Developmental Services of Illinois, Inc.-Management fees (4,187)Yellow page advertising Center for Residential Management, Inc.-Management fees 6.247 TOTAL (agree to Schedule V, TOTAL (agree to Sch. V, 34,298 3,663 line 22, col.8) line 20, col. 8) TOTAL (agree to Schedule V, line 17, col. 3) 2,060 E. Schedule of Non-Cash Compensation Paid G. Schedule of Travel and Seminar\*\* (Attach a copy of any management service agreement) to Owners or Employees C. Professional Services Description Amount Vendor/Payee Type Amount Description Line# Amount **Personnel Planners U/C Consultation** 200 Out-of-State Travel Mangum, Smietanka & Johnson Legal 2,694 Lawrence A. Manson Legal 729 American Express Tax & **In-State Travel** 3,395 **Business Services** 332 Accounting Altschuler, Melvoin & Glasser LLP 2,277 Accounting Seminar Expense 169 Management & Parent Co. Allocations 1,348 **Entertainment Expense** TOTAL (agree to Schedule V, line 19, column 3) TOTAL (agree to Sch. V.

> \* Attach copy of IMRF notifications SEE ACCOUNTANTS' COMPILATION REPORT

TOTAL

\*\*See instructions.

line 24, col. 8)

4,912

6,232

(If total legal fees exceed \$2500 attach copy of invoices.)

# Briarbrook Place Facility # 0038232 June 30, 2001

### Schedule 21C

XIX. Support Schedules C. Professional Services

	<u>Type</u>	<u>Amount</u>
Total agrees to Schedule V, line 19, column 3		6,232
Allocated from parent company Altschuler, Melvoin & Glasser LLP American Express Tax & Business Services Mangum, Smietanka & Johnson Lawrence Manson	Accounting Accounting Legal Legal	613 309 660 382
Allocated from management company     American Express Tax & Business Services     Altschuler, Melvoin & Glasser LLP     ADP     Health Outcomes	Accounting Accounting Payroll Consulting	702 1,472 2,549 116
Total agreeing to Schedule V, line 19, column 8		13,035

**See Accountants' Compilation Report** 

# XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3). (See instructions.)

	(See instructions.)												
	1	2	3	4	5	6	7	8	9	10	11	12	13
		Month & Year						Amount of	Expense Amor	tized Per Year			
	Improvement	Improvement	Total Cost	Useful									
	Type	Was Made		Life	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9	N/A												
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

	S	TATE C	OF ILLINOIS				Page 23
	y Name & ID Number Briarbrook Place	#	0038232	Report Period Beginning:	07/01/00	Ending:	06/30/01
	ENERAL INFORMATION:						
(1)	Are nursing employees (RN,LPN,NA) represented by a union?  No			supplies and services which are of the Public Aid, in addition to the daily r			
(2)	Are there any dues to nursing home associations included on the cost report? Yes  If YES, give association name and amount. Illinois Health Care Association-\$794		,	ection of Schedule V? Yes			C
(3)	Did the nursing home make political contributions or payments to a politica action organization?  No  If YES, have these costs been properly adjusted out of the cost report?  N/A	, ,	the patient census is a portion of the	building used for any function other listed on page 2, Section B? No building used for rental, a pharmacy, explains how all related costs were al	, day care, etc.)	For example If YES, attac	e,
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A	` /	Indicate the cost o on Schedule V. related costs?		ssified to employ meal income be the amount. \$	oeen offset ag	ainst
(5)	Have you properly capitalized all major repairs and equipment purchases?  What was the average life used for new equipment added during this period?  n/a  n/a		Travel and Transp	ortation included for out-of-state travel?	No		
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $\frac{1,454}{2}$ Line $\frac{10(2)}{2}$		If YES, attach a	complete explanation. separate contract with the Departmen	t to provide me		
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports?  Yes  If NO, attach a complete explanation.		program during c. What percent of	this reporting period. \$ n/a Fall travel expense relates to transporting age logs been maintained?  Adequate	tation of nurses	s and patients	? <b>58%</b>
(8)	Are you presently operating under a sale and leaseback arrangement.  If YES, give effective date of lease.  No  No		e. Are all vehicles times when not	stored at the nursing home during th	e night and all	otheı	
(9)	Are you presently operating under a sublease agreement? YES NO		out of the cost r				No
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO $x$ If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took over	,	Indicate the a transportatio	mount of income earned from p n during this reporting period.	oroviding suc \$	h S <u>N/A</u>	_
	N/A			performed by an independent certific	ed public accou		
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 36,096  This amount is to be recorded on line 42 of Schedule V.		cost report require	that a copy of this audit be included  No  If no, please explain.			
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?  No If YES, attach an explanation of the allocation.	, ,	out of Schedule V		C	v	
	SEE ACCOUNTANTS' COMPILATION REPORT	` /	performed been at	tree in excess of \$2500, have legal invalued to this cost report?  Yes  In a summary of services for all architectures.		,	ices

						Daalaaa	DI:6-		اد عدد
		Calarias	Cumpling	Other	Total	Reclass-	Reclassifie		Adjusted
1 D		Salaries 18,346	Supplies 2,344	1.731	Total 22,421	ifications 0	Total 22.421	Adjustmen 0	
	ood P	10,340	26,961	1,731	26,961	0	26,961	-3,060	22,421 23,901
	lousek	0	2,887	0	2,887	0	2,887	-3,000	2,887
	aundr	0	963	0	963	0	963	0	963
	leat ar	0	0			0		64	10,143
	leat ai lainter	10,003	0	,	22,471	0	22,471	1,019	23,490
	Other (s	0,000	0	0	0	0	0	0,010	20,430
	otal G	28,349	33,155		85,782	0	85,782	-1,977	83,805
0. 1	otal O	20,010	00,100	21,270	00,702	·	00,102	1,011	00,000
9. M	/ledical	0	0	660	660	0	660	0	660
10.	Nursin	120,765	4,500	2,569	127,834	0	127,834	0	127,834
	Thera	0	0	310	310	0	310	0	310
11.	Activit	0	5,618	578	6,196	0	6,196	1,702	7,898
12.	Social	0	0	365	365	0	365	0	365
13.	Nurse	0	0	0	0	0	0	0	0
14.	Progra	0	0	2,907	2,907	0	2,907	0	2,907
15.	Other	0	0	550	550	0	550	0	550
16.	Total I	120,765	10,118	7,939	138,822	0	138,822	1,702	140,524
17.	Admin	38,903	0	2,060	40,963	0	40,963	-2,060	38,903
18.	Direct	0	0	0	0	0	0	4,706	4,706
19.	Profes	0	0	6,232	6,232	0	6,232	6,803	13,035
20.	Fees,	0	0	2,401	2,401	0	2,401	1,262	3,663
21.	Clerica	14,138	3,833	6,663	24,634	0	24,634	12,788	37,422
22.	Emplo	0	0	12,385	12,385	0	12,385	21,913	34,298
23.	Inserv	0	0	10	10	0	10	299	309
24.	Travel	0	0	2,974	2,974	0	2,974	1,938	4,912
25.	Other	0	0	1,941	1,941	0	1,941	178	2,119
	Insura	0	0	0	0	0	0	4,512	4,512
	Other	0	0	0	0	0	0	0	0
28.	Total (	53,041	3,833	34,666	91,540	0	91,540	52,339	143,879
29.	Total (	202,155	47,106	66,883	316,144	0	316,144	52,064	368,208
	Depre	0	0	2,826	2,826	0	2,826	18,819	21,645
31. /	Amort	0	0	0	0	0	0	0	0
	Interes	0	0	2,942	2,942	0	2,942	57,285	60,227
	Real E	0	0	0	0	0	0	0	0
	Rent -	0	0	66,872	66,872	0	66,872	-65,102	1,770
	Rent -	0	0	9,854	9,854	0	9,854	807	10,661
	Other	0	0	0	0	0	0	0	0
37.	Total (	0	0	82,494	82,494	0	82,494	11,809	94,303
38.	Medic:	0	0	0	0	0	0	0	0
39.	Ancilla	0	0	495	495	0	495	381	876
40. l	Barbe	0	0	0	0	0	0	0	0
41.	Coffee	0	0	0	0	0	0	0	0
42.	Provid	0	0	36,096	36,096	0	36,096	0	36,096
43.	Other	0	0	130,879	130,879	0	130,879	-130,879	0
44.	Total 5	0	0	167,470	167,470	0	167,470	-130,498	36,972
45.	Grand	202,155	47,106	316,847	566,108	0	566,108	-66,625	499,483

	A	After
(	Operating (	Consolidation
General Sei		
1. Cash on	372	372
2. Cash - F	0	0
3. Account	109,760	109,760
<ol><li>Supply I</li></ol>	0	0
<ol><li>Short-T€</li></ol>	0	0
<ol><li>Prepaid</li></ol>	2,256	2,256
<ol><li>Other Pi</li></ol>	21,755	21,755
<ol><li>Account</li></ol>	701,178	701,178
9. Other (s	720	720
10. Total c	836,041	836,041
LONG TER		,
11. Long-T	0	0
12. Long-T	0	0
13. Land	0	20,000
14. Buildin	3,321	733,321
15. Leaseł	0	0
<ol><li>Equipn</li></ol>	26,441	26,441
17. Accum	-15,171	-57,755
<ol> <li>18. Deferre</li> </ol>	0	0
19. Organi	0	0
20. Accum	0	0
21. Restric	0	0
22. Other I	0	0
23. other (	0	36,005
24. Total L	14,591	758,012
25. Total A		1,594,053
CURRENT		
	63,278	
26. Accour	,	63,278
27. Officer	0	0
28. Accour	0	0
29. Short-7	45,185	45,185
30. Accrue	12,175	12,175
31. Accrue	0	0
<ol><li>32. Accrue</li></ol>	0	0
<ol><li>Accrue</li></ol>	0	0
<ol> <li>34. Deferr€</li> </ol>	0	0
<ol><li>35. Federa</li></ol>	0	0
36. Other (	18,059	18,059
37. Other (	0	0
38. Total C	138,697	138,697
LONG TER		
39.Long-Te	3,392	3,392
40.Mortgag	0,002	0
41.Bonds I	0	
		793,915
42.Deferre	0	0
43.Other L	0	0
44.Other L	0	0
45.Total Lo	3,392	797,307
46.Total Li	142,089	936,004
47.Total E	708,543	658,049
48.Total Li	850,632	1,594,053

Balance per Medicaid Trial Balance 1. Gross F 659,980 2. Discour Subtota 659,980 4. Day Ca 0 5. Other C 0 6. Therapy 0 7. Oxygen 0 Subtota-9. Paymer 133,451 10. Other 11. Nurse: 3,186 12. Gift an 13. Barbei 0 14. Non-P 0 15. Teleph 0 16. Rental 0 17. Sale o 0 18. Sale o 0 19. Labora 0 20. Radiol 0 21. Other 0 22. Laund 0 Subtot 136,637 24. Contril 0 25. Interes 109 Subtot 109 27. Other 10 28. Other 0 Subtot 10 30. Total F 796,736 31. Gener 584,584 32. Health 1,451,643 33. Gener 1,455,763 34. Owner 640,040 35. Specia 1,279,487 35. Provid 192,397 37. Other 40. Total E 5,603,914

41. Incom ########

42. Incom 0 43. Net In: ########

```
Page
      2
      3
      6
     10 Attachment of Real Estate Bill and fill out form
     11
     12 P12 does not show totals, it carries to P12a, therefore P12a must always be attached
     13
     14
     15
     16
     17
     19 The bottom right side of page under **, you must write in any comments
     20
     21
     22
     23
```

RECONCILIATION REPORT Briarbrook Place		02:10 PM	11/07/05										
							SUB-	LINE	COL.	•	SUB-	LINE	COL.
ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SCHED.	NO.	NO.	WITH CELL	SCHED.	NO.	NO.
							_			L			_
Adjustment Detail	-66,625 60.227		-66,625 60.227	0	O.K. O.K.	Pg5 Z22	В.	37 15	1	Pg4 K29	N/A N/A	45 32	7 8
	60,227	equal to	60,227	0	O.K.	Pg9 P34	A. B	15 5	N/A	Pg4 L13	N/A N/A	32	8
Real Estate Tax Expenses  Amortization exp. Pre-opening & org.	N/A	equal to equal to	0	#VALUE!	#VALUE!	Pg10 W24 Pg11 I33	В.	3	N/A N/A	Pg4 L14 Pg4 L12	N/A N/A	33	8
			21,645	#VALUE!	#VALUE! O.K.	-	E.	3 49	N/A 2	-	N/A N/A	31	8
Ownership Costs-Depreciation Rental Costs A	21,645			0	O.K.	Pg13 Y28		49 7 + 8	2 4+N/A	Pg4 L11	N/A N/A	30 34	8
Rental Costs B	1,770		1,770 10,661	0	0.K.	Pg14 L20+N22	A. B.+ C.	7 + 8 16+21	4+N/A N/A+4	Pg4 L15 Pg4 L16	N/A N/A	35	8
Nurse Aid Training Prog.	10,661	equal to equal to	10,001	0	0.K.	Pg14 J30+N40 Pg15 L36	B.+ C. B.	10+21	1 1	Pg3 L23	N/A N/A	13	8
Special Serv Staff Wages	0		U	0	0.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
•	240	equal to	310	0	O.K.	Pg16 X12+Z14	N/A:B	1-4:40-43		-		10a	4
Therapy Services	310		#VALUE!				,	,	8;2 6	Pg3 H20	N/A		2
Special Serv Supplies Income Stat. General Serv.	381	equal to		#VALUE!	#VALUE!	Pg16 V32	N/A N/A	14 31	2	Pg4 F22 + Pg 3	N/A N/A	39,10a 8	4
Income Stat. General Serv.	85,782 138.822	equal to	85,782 138,822	0	O.K. O.K.	Pg19 P11 Pg19 P12	N/A N/A	32	2	Pg3 H16	N/A N/A	16	-
Income Stat. Health Care Income Stat. Admininstation	138,822		138,822 91,540	0	O.K.	Pg19 P12 Pg19 P13	N/A N/A	32	2	Pg3 H26 Pg3 H39	N/A N/A	16 28	4
								33		-			4
Income Stat. Ownership	82,494	equal to	82,494	0	0.K.	Pg19 P15	N/A	34 35	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	131,374		131,374		0.K.	Pg19 P17	N/A	35 36		Pg4 H21H24+F	N/A	38to41+43	4
Income Stat. Prov. Partic.	36,096		36,096	0	0.K. 0.K	Pg19 P18	N/A	36 1-5 24 25 27-30	2	Pg4 H25	N/A	42 10	-
Staff- Nursing	120,765	-	120,765	-		Pg20 K11K15+	Α.	,,,	3	Pg3 E19	N/A		1
Staff- Nurse aide Training	0			0	O.K.	Pg20 K16	Α.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0			0	O.K.	Pg20 K17	Α.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	0			0	O.K.	Pg20 K19+K20	Α.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	0			0	O.K.	Pg20 K21	Α.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	18,346		18,346	0	O.K.	Pg20 K22K26	Α.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	10,003	-	10,003	0	O.K.	Pg20 K27	Α.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	0			0	O.K.	Pg20 K28	Α.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	0			0	O.K.	Pg20 K29	Α.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	38,903		38,903	0	O.K.	Pg20 K30K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	14,138		14,138	0	O.K.	Pg20 K33K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0			0	O.K.	Pg20 K37	Α.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	202,155		202,155	0	O.K.	Pg20 K44	Α.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	1,731	< or = to	1,731	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	660		660	0	O.K.	Pg20 X13	В.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	164	< or = to	2,569	-2,405	O.K.	Pg20 X14X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	1,702		578	1,124	FAILED	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	365		365	0	O.K.	Pg20 X22	В.	45	2	Pg3 G22	N/A	12	3
Supp. Sched Admin. Salar.	38,903		38,903	0	O.K.	Pg21 I16	Α.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched Admin. Other	2,060		2,060	0	O.K.	Pg21 I24	В.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched Prof. Serv.	6,232		6,232	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched Benefit/Taxes	34,298	equal to	34,298	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched Sched of dues	3,663	equal to	3,663	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched Sched. of trav	4,912		4,912	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	36,096		36,096	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	3,060		21,913	-18,853	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	3,060	-	3,060	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0		_	0	O.K.	Pg15 U29U31	В.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	N/A	equal to	0	#VALUE!	#VALUE!	Pg2 AB29	K.	N/A	N/A	Pg2 J30	В.	8	4
Adjustment for related org. costs	69,157	equal to	69,157	0	O.K.	Pg5 Z18	В.	34	1	Pg6 to Pg 6I Y40	В.	14	8
Total loan balance	842,492		842,492	0	O.K.	Pg9 L34	Α.	15	7	Pg17 V13+V27	N/A	29+39-41	2
Real estate tax accrual	0			0	O.K.	Pg10 W15	В.	4	N/A	Pg17 V17	N/A	32	2
Land	20,000	-	20,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	733,321	equal to	733,321	0	O.K.	Pg12 to 12I L43	В.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	26,441	equal to	26,441	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	57,755		57,755	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	708,543	equal to	708,543	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	230,628	-	230,628	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	-		0	O.K.	Pg22 F31-J318	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	850,632	equal to	850,632	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1